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ABSTRACT

Under Oklahoma's new "in need of treatment" (INT) procedure, juvenile commitments have increased 10 times since 1983. About 8% of commitments are American Indian children. Generally, the mental health dilemma of Indian communities is characterized by multiple and interacting problems, acute symptoms masked by related problems such as alcoholism or delinquency, diagnoses complicated by different cultural values and symptom patterns, the pervasiveness of depression in Indian communities, and tendencies to experience psychological problems as physical illness. Studies suggest that Indian adolescents have more serious problems than youth of other races with respect to developmental disorders, post-traumatic stress disorder, identity disorder, depression, suicide, anxiety, substance abuse, and adjustment or behavior disorders. Environmental risk factors include otitis media, fetal alcohol syndrome, child abuse and neglect, parent alcoholism, and early death of parents. However, only 1-2% of the Indian Health Service budget goes to mental health services. When Indian children receive therapy, it may be based on white cultural assumptions that overlook cross-cultural value differences. Current INT programs threaten Indian communities in two major ways--by not meeting the treatment needs of Indian children, and by removing youth from Indian communities at an alarming rate. Sovereignty can provide a solution through enhanced enforcement of the Indian Child Welfare Act (recognition that INT procedures are in fact foster care placements), and through service agreements with state agencies to develop tribal mental health services and home-based care programs. (SV)

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SOVEREIGNTY SYMPOSIUM IV

Oklahoma City, Oklahoma

The Circles of Sovereignty

"PROTECTING OUR YOUTH - PRESERVING OUR FUTURE SOVEREIGNTY'S IMPACT ON CHILDREN IN NEED OF TREATMENT"

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PROTECTING OUR YOUTH - PRESERVING OUR FUTURE
SOVEREIGNTY'S IMPACT ON CHILDREN IN NEED OF TREATMENT

> "To break sharply with the past is to court the madness that may follow...As the sanity of the individual lies in the continuity of his memories, so the sanity of a group lies in the continuity of its traditions; in either case a break in the chain invites a neurotic reaction."
>
> - Will & Ariel Durant, The Lessons of History (1968).

> "While Native Americans suffer from the same types of mental disorders as other Americans, the prevalence and severity of these disorders appear to be greater, the availability of services lower, the cultural relevance of treatment plans more challenging, and the social context more disintegrated than in almost any part of American society. Failure to address these issues will result in more severe emotional problems for future generations of Native American individuals, families, and communities."
>
> - Indian Health Service, Mental Health Programs Branch, "A National Plan for Native American Mental Health Services", 10th draft, unpublished report, Rockville, MD, June 26, 1989.

INTRODUCTION

As an intern in the Juvenile Division of the Oklahoma County District Attorney's Office, I saw children whose lives were forever scarred by abuse, neglect and sexual molestation. After a few weeks, I ceased to be shocked by the horror stories which unfolded each day and developed the "professional distance" to view those cases as items of business - with one glaring exception. Some six years later, I am still haunted by the tear streaked face of a sixteen year old Indian girl screaming "I am not crazy!"

She first entered the juvenile system at age nine as a deprived and neglected child. At thirteen she was labeled In Need

of Supervision and by fourteen had been adjudicated a Delinquent. Her seven year trek through Oklahoma's system had landed her in countless foster homes, group placements and juvenile institutions. The authorities were particularly perplexed by her case because she had such "potential", but was, in their view, "lazy" and "bullheaded". The new In Need of Treatment (INT)[1] procedure for juvenile commitments seemed the best and final option since "nothing else had worked".

As I stood in the courtroom watching her plead, "I may be bad, but I am not crazy!", it became obvious to me that she was a child torn between two cultures, who came from a dysfunctional family, who was removed from tribal support systems and who was using every bit of beauty and brilliance she possessed to survive in a chaotic world. Admittedly, she had needs, but her needs were not being met by the State of Oklahoma. For her, the INT procedure merely meant she would be "abused at better prices."[2]

This paper discusses the treatment needs of Native American youth, the culture clash which impedes effective diagnosis and treatment and the opportunity sovereign tribes have to develop programs to protect our youth.

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[1] 10 O.S. §1101(5) et. seq. See Appendix A and discussion at pp. 14-15.

[2] Schwartz, Ira M., (In) Justice for Juveniles, (1989). An over abundance of hospital beds and generous third-party health care programs have made psychiatric hospitals and chemical dependency units the new jails for troublesome kids. "Children are usually committed for behavior problems that do not require hospitalization and for which there is little evidence that psychiatric intervention is appropriate or effective." Id. at 143.

I. TREATMENT NEEDS

Terry L. Cross, M.S.W., Director of the Northwest Indian Child Welfare Institute, provides a snapshot view of Indian youth in the mental health system:

> "If you are a Native American child and seriously emotionally disturbed, you will likely go without treatment or be removed legally and geographically from your family and tribe to receive treatment. If you are a Native child your chances of being placed outside your home and community is almost four times greater than a non-minority child...and the likelihood that you will get help specifically designed for your needs is very slim. If you act out and are Native, chances are you will end up in the Juvenile Justice system rather than mental health system. If you are diagnosed seriously emotionally disturbed as a Indian child, you are more likely to be labeled "schizophrenic" or "character disorder" unlike your non-Indian peers who are more likely to be diagnosed "depressed" or "adjustment reaction".[3]

A. INT Placements in Oklahoma.

The number of INT adjudications in Oklahoma has increased steadily each year from 41 in 1983 to 413 in 1989.[4] Overall, approximately 8% of these children have been American Indians.[5]

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[3] Cross, Terry L., "Cultural Issues and Responses: Defining Cultural Competence in Child Mental Health" in Encircling Our Forgotten (1989). (Encircling Our Forgotten is the conference proceedings publication from the annual Conference on Mental Health Issues for the Emotionally Disturbed North American Indian Child and Adolescent. For more information, contact the American Indian Institute, University of Oklahoma).

[4] Letter from Marla C. Graham, Director of Mental Health Services for Youth, Oklahoma Dept of Mental Health (March 20, 1991).

[5] Id.

Oklahoma has a higher out-of-home placement rate than other states, especially for minority children.[6]

Last year, Oklahoma spent $57 Million, mostly in Medicaid dollars, to keep children in psychiatric institutions.[7] While the recommended number of beds is five per 10,000 children, Oklahoma has 16 per 10,000, for a total of 1,300 psychiatric beds statewide.[8]

B. Emotional Problems Faced by Indian Youth.

Generally, the mental health dilemma faced by Indian communities can be characterized by certain key factors:

- multiple and interacting problems
- acute symptoms often being masked by related problems (such as alcoholism, delinquency, violence or physical illness)
- diagnosis being complicated by different cultural values and symptom patterns
- the pervasiveness of depression in Indian communities
- a tendency to experience emotional and psychological problems as either physical illness or as caused by external stress only.[9]

Findings suggest that Indian adolescents have more serious problems than youth of other races with respect to: developmental

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[6] Id.

[7] Tulsa World, (1991) - Medicaid dollars are not currently available for outpatient treatment.

[8] Id.

[9] Clarke, Jennifer C., "Therapeutic Framework: Cultural Congruence in a Tribal Mental Health Program" in Encircling Our Forgotten (1990).

disorders, post-traumatic stress disorder (PTSD), identity disorder, depression, suicide, anxiety, substance abuse and adjustment or behavioral disorders.[10]

1. **Developmental Disorders**.

Perhaps due to the extraordinarily high prevalence of otitis media and fetal alcohol syndrome, almost 10 percent of American Indian students in public schools suffer from some sort of developmental disability. The frequency of learning disabilities among Indian children is higher than any other minority group.[11]

2. **Post-Traumatic Stress**.

Phil Tingley explains why Native Americans, like war survivors or abuse victims, tend to exhibit symptoms of Post-Traumatic Stress Disorder:

> "American Indians are survivors of from one to five hundred years of the most brutal genocide, ethnocide and forced acculturation the world has ever seen. For the past five generations, we have experienced one cultural and individual trauma after another.
>
> My great-grandparents were prisoners-of-war. My grandparents experienced the concentration camp existence of our first reservations. My parents suffered involuntary confinement at boarding schools. And I spent my elementary school years away from my family in religious boarding schools.
>
> Each of these generations experienced a number of additional, individualized traumas including beatings, sexual abuse, premature

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[10] U.S. Congress, Office of Technology Assessment (OTA), "Indian Adolescent Mental Health" (January 1990).

[11] Id. at 13-14.

deaths of loved ones and all kinds of social, psychological and spiritual degradation."[12]

While Indian children are no longer forced to endure boarding school isolation, they are forced into a dominant society whose values and rewards differ greatly from the Native culture.[13] Today's youth also deal with secondary PTSD through parents and grandparents who are still effected by the severe trauma of the past. Because children learn to respond to the world by the way their elders respond, reactive behaviors used by parents and grandparents may be adopted by today's children.[14]

3. **Identity Disorder**.

Identity Disorder results when a person has difficulty integrating the various aspects of self into a coherent sense of personhood.[15] Whether urban or rural, contemporary or traditional, many Indian youth have difficulty merging the white and native world views into a positive self identity.[16]

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[12] "What Does PTS Have To Do With Native Americans?"

[13] Patchell, Beverly, "Child Suicide" in Encircling Our Forgotten (1989).

[14] Supra note 12.

[15] OTA, Supra note 10 at 22.

[16] Id. For further information on Urban Indians, see Biron, T., "Community Health and Michigan Native Americans" in Encircling Our Forgotten (1988).

4. **Depression.**

As much as 40 percent of the daily patient case load in IHS clinics can be attributed to depression.[17] Accurate diagnosis of depression disorder is hampered by behavioral, developmental and substance abuse problems which are often the result of underlying depression.[18] Over 50 percent of Indian adolescents report serious depressive symptoms.[19]

5. **Suicide**

Suicide is now the second leading cause of death for American Indian adolescents.[20] The American Journal of Public Health reports that from 1980-1985, the national suicide rate for 10-14 year olds more than doubled.[21] Suicide deaths for Indian children age 10-14 is four times higher than that for all U.S. races.[22]

Nearly 12 percent of Indian males and 20 percent of Indian females have attempted suicide.[23] Unfortunately, these cries for help are all too often unanswered. Of those adolescents who have attempted suicide, 75 percent receive no mental health treatment.

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[17] Belgarde, M.; La Fromboise, T; and Hayes, L.; "The Zuni Tribe Suicide Curriculum" in Encircling Our Forgotten (1989).

[18] OTA, Supra note 10, p. 14.

[19] Id.

[20] Id. at 16.

[21] Patchell, Supra note 13 at 1.

[22] OTA, Supra note 10 at 16.

[23] Id. at 18.

Suicide has a profound impact on the lives of survivors as well:

> "Nearly one-third of females and one-fifth of males indicated that a friend had attempted suicide. One out of ten Indian adolescents reported that a friend had actually died from suicide. About one-fifth of those surveyed indicated that a family member had either committed or attempted suicide."[24]

6. **Anxiety**.

Indian adolescents exhibit remarkably high levels of different forms of anxiety. Like depression, anxiety related disorders are evident, but are not well documented or delineated. Fearfulness, avoidant behavior, nightmares and phobias are all common forms of anxiety which can impair a child's life.[25]

7. **Substance Abuse**.

Without question, Indian youth suffer from high rates of alcohol, drug and inhalant abuse and/or addiction. American Indians typically begin abusing substances at a younger age and are more likely to suffer from multiple addictions than their white counterparts.[26]

8. **Conduct Disorders**.

A conduct disorder is "a persistent pattern in which the basic rights of others and major age-appropriate societal norms or rules

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[24] Id.

[25] Id. at 20.

[26] Id. at 22.

are violated".[27] The behaviors associated with this disorder include: running away, lying, truancy, vandalism, stealing and fighting.[28]

9. Risk Factors.

Numerous environmental risk factors contribute to the mental health problems faced by Indian adolescents. Physical disorders, such as otitis media (middle ear infection) and fetal alcohol syndrome, increase the risk of learning, developmental and neurosensory disorders.[29] In most studies, child abuse and neglect in Indian communities equals or exceeds abuse rates in non-Indian communities.[30] Nearly a quarter of native children come from homes with at least one alcoholic parent.[31] Finally, the risk that a child will be left alone through the death of both parents is 10 times greater for an Indian child than a non-Indian child.[32]

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[27] Id. at 23.

[28] Id. A dropout rate at 15-60 percent higher than the national average, a higher propensity for status and alcohol related crimes, and growing runaway rates are all viewed as conduct disorder indicators for Indian youth.

[29] Id. at 26-27. Otitis media is the most frequently identified disease of Indian children, causing hearing loss, delays in cognitive and psycholinguistic development, and lowered educational achievement. Id. As many as 75 percent of all Indian kids experience this disease. Fetal Alcohol Syndrome's effects on a child's life can be seen in the fact that, apart from the neurological damages inflicted, 73 percent of FAS Indian children are adopted or placed in foster homes due to neglect or abandonment.

[30] Id. at 27.

[31] Id. at 30.

[32] Id. Twelve percent of native youth report that one or both parents are dead.

10. **IHS Treatment Resources.**

The federal government is inadequately equipped to deal with these problems. IHS has only 17 trained juvenile mental health providers to serve over 397,000 kids nationwide.[33] Only 1-2 percent of the IHS budget goes to mental health services.[34] The Oklahoma City IHS Service Area has 1 worker to serve an estimated juvenile population of 48,090 kids.[35]

II. CULTURE CLASHES IN DIAGNOSIS AND TREATMENT

Psychological counseling and psychiatric therapy are based upon assumptions which "reflect the social, economic and political context of Western cultures as well as imply the universal applicability of these assumptions in non-Western cultures".[36] Ethnocentric assumptions lead to all kinds of distortions in everyday encounters between people of different cultures. Yet, when such false assumptions arise between a client and a therapist, erroneous diagnosis and treatment may occur resulting in a waste of services and potential harm to the client.[37]

Even considering the differences among the 478 tribes recognized by the BIA, certain generalizations can be drawn which

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[33] Id. at 1,

[34] Id.

[35] Id.

[36] Pedersen, P.; "Cultural Inclusiveness in Counseling" in Counseling Across Cultures (1981).

[37] Trimble, J., "Value Differentials and Their Importance in Counseling American Indians" in Counseling Across Cultures (1981).

identify value differences between the Indian and majority cultures:

- Present-oriented versus future-oriented: The Indian lives in the present and he is not concerned about what tomorrow will being, but enjoys now. The non-Indian lives for tomorrow, constantly looking to and planning for the future.

- Lack of time consciousness versus time consciousness: Many tribal languages have no word equivalent to the English word. For the Indian there is always time to get things accomplished even if not completed today. The non-Indian's life, on the other hand, is governed almost entirely by time. Those who are prompt are respected and those who are not are usually rejected and reprimanded.

- Generosity and sharing versus personal acquisitiveness and material achievement: The Indian gets in order to give. The one who gives the most commands the most resect. By contrast, the non-Indian is judged by what he or she has, so that material achievement means acquiring many possessions, which in turn carry the hope of social mobility.

- Respect for age versus emphasis on youth: The Indian respects a person who has knowledge of the people and the world around him. The older Indians are respected for their wisdom and knowledge. The non-Indian society places a greater importance on youth, an emphasis seen daily on television and in politics, for example.

- Cooperation versus competition: The Indian learns to get along with others and values working with others. In the Indian group there is conformity, not competition. The non-Indian believes that competition is essential. Progress results from competition and lack of progress may be synonymous with lack of competition. Every aspect of daily living in the non-Indian culture is quite competitive.

- Harmony with nature versus conquest over nature: Nature, in the Indian view of the world, is indivisible and a person is only a part of that one thing. The Indian accepts the world and does not try to change it. The non-Indian attempts to control the physical world, to assert mastery over it - the more control over nature the better.[38]

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[38] Bryde, J., Indian Students and Guidance (1972).

As explained by Oklahoma Supreme Court Justice Yvonne Kauger:

> "Indian lifestyles differ markedly from those of the non-Indian world. Continuing tribal traditions result in a world view and a concept of group identity which create a culture within a culture, the values of which generally are unknown, unnoticed, or unrecognized by those who are unacquainted with tribal customs. The significant differences in tribal values concerning heritage, kinship, concepts of time, scheduling seasonal activities, geographical location, race, religion, economics, language, historicity, sexual mores, and family practices and structure must be recognized, notwithstanding their apparent incompatibility with middle class mores."[39]

Recognition of cultural diversity is essential to the delivery of effective treatment. Otherwise, deviations from white middle class norms may be interpreted as mental illness rather than mere value differences.[40] For example, like most first-time clients, an Indian youngster may respond to an unfamiliar treatment situation with silence or apparent non-attentiveness. When the adolescent does not eagerly engage in self-disclosure, an Anglo counselor may label the child as "hostile" or "guarded".[41] Such an erroneous diagnosis will lead to improper or unnecessary treatment.

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[39] In the Matter of the Adoption of Baby Boy D, 742 P.2d 1059, 1074-75 (1985)(Kauger, J., concurring in part and dissenting in part).

[40] Trimble, Supra note 37 at 205; Pedersen, Supra note 36 at 27.

[41] Trimble, Supra note 37 at 204. Another difficulty encountered by Native youth in need of treatment is the current fascination with Indian culture. A counselor may become so preoccupied with the hidden cultural differences in each sentence and gesture that the child's actual mental health problems are completely ignored. Id. at 223.

III. SOVEREIGNTY AS A SOLUTION TO INT TREATMENT PROBLEMS

The failures of current INT programs threaten tribal communities in two major ways: (1) our youth are being removed from tribal communities at an alarming rate and (2) our youth's treatment needs are not being met. Sovereignty can provide a solution to these problems through enhanced enforcement of the Indian Child Welfare Act and Service Agreements with State Agencies.

A. The Indian Child Welfare Act.

Indian Child Welfare Act of 1978, codified at 25 USC §1901, was enacted to combat longstanding attempts to destroy tribal communities by the forced assimilation of Indian children into white society:

> Well before this country became a nation, the insensitive precedent had been cast to destroy Indian culture and tribal cohesiveness by removing Indian children from their families and tribal environments. Continuing separation of Indian children from their heritage is one of the most tragic and destructive aspects of contemporary Indian life. State intrusion into Native American parent-child relationships impedes the ability of the tribe to perpetuate itself, and, ultimately, it unjustifiably results in a coerced assimilation of the First Americans into a larger more homogenous society.[42]

Both the federal ICWA[43] and Oklahoma's ICWA[44] establish minimum standards for the removal and placement of Indian children.

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[42] Adoption of Baby Boy D., supra note 39 at 1072.

[43] 25 USC §1901, et. seq.

[44] 10 OS §40, et. seq.

The ICWA applies to "child custody proceedings" including:

> "Foster care placement" which shall mean any action removing an Indian child from its parent or Indian custodian for temporary placement in a foster home or institution or the home of a guardian or conservator where the parent or Indian custodian cannot have the child returned upon demand, but where parental rights have not been terminated;"[45] (emphasis added).

Oklahoma's INT procedure should be viewed as a "foster care placement" under the ICWA. Once a child is adjudicated INT, the Oklahoma courts retain jurisdiction until the child reaches age 18.[46] Even before adjudication, the court can hospitalize the child for mental health examination.[47] After adjudication, whether legal custody remains with the parents or is granted to the Department of Human Services, the court can impose inpatient care.[48] Perhaps most frightening, under the Interstate Compact on Mental Health the state can transfer INT children to institutions in other states.[49]

Even though such actions are obviously "custody proceedings" under the ICWA definition, a recent survey indicated that only 62 percent of Oklahoma's judges comply with the ICWA in INT

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[45] 25 USC §1903(1)(i).

[46] 10 OS §1102(A).

[47] 10 OS §1105(B).

[48] 10 OS §1116(A)(5).

[49] See generally, Moreland, "Our Forgotten Once Again Forgotten by the Interstate Compact on Mental Health: A Psycho-Legal Discourse on Preserving American Indian Families with Severely Emotionally Disturbed Children" in Encircling Our Forgotten (1988).

proceedings.[50] If the notice procedures provided in the ICWA were strictly followed, tribes would have the opportunity to protect these Indian adolescents.

Conferences and workshops dealing with sovereignty classically focus on protecting and preserving sovereign tribal powers. In the context of INT youth, however, we must begin to explore the possibilities inherent in our status as sovereign nations. We must begin to create and fund programs which will protect our children and preserve our future.

Each tribe must begin to develop a juvenile mental health system based on cultural congruence - providing services at the tribe which are integrated in tribal programs and developed within a tribal context.[51] As the Salish - Kootenai Tribe has discovered:

> "The solution must come from within the communities. Others may assist but we the people must be the subject of our healing process and must direct that process ourselves in our own way....The well-being of the individual is inseparable from the well-being of the community. Individual healing and the healing of the entire community must go hand-in-hand."[52]

Tribally based services can provide culturally competent care in the least restrictive environment while building pride and understanding of the Indian culture. "Until a person can accept and appreciate his culture, he is not free to explore one's own

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[50] Strubhar, R., "Indian Child Welfare Act: A View from the State Courts" in Sovereignty Symposium III (1990).

[51] Clark, J., supra note 9 at 25.

[52] Blue Boy: A Tribal Approach to Fighting Alcohol and Drug Abuse.

individuality, appreciate other cultures or make constructive life decisions. He is stuck fighting old battles against others or even against his own people".[53]

Even Indian youth who grow up in urban areas need to come to grips with their tribal identities. As Steven B. Pratt explains, we can't expect Indian kids to be mentally healthy without a tribal identity:

> "We forgot to teach them that they also have an identity. They must learn. It just doesn't happen. You are not born with it. You have to experience it. You have to live it. You have to be part of it. That is where most of our problems are coming from now."[54]

Tribal mental health systems can fill the learning gaps created by the clash with the Anglo world and facilitate the development of the adults needed to ensure cultural survival:

> "The Indian child is ideally taught a complex network of family relationships, degrees of "closeness" and social relationships based on mutual respect and cooperation. The psychologically-mature Indian adult is one who has achieved a balanced and adapted relationship to his/her family and tribe; he/she functions smoothly in the tribal system of shared responsibility and mutual exchanges; he/she is responsive to community opinion and is deeply concerned for the overall welfare of the extended family and tribal group."[55]

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[53] Clark, supra note 9 at 28.

[54] Pratt, S., "Quest for an Identity-Indian Youth in a Non-Indian World: Cultural Identity and How it Affects Native Youth" in Encircling Our Forgotten (1990).

[55] Clarke, supra note 9 at 26.

The exact nature of such services will be dictated by a Tribe's geographic location, cultural traditions, funding options and staff availability. For example, to deliver services to rural Navajo and Hopi youth, a Mobile Child Psychiatry Team was formed in 1986. A child psychiatrist, a child psychologist, a psychiatric social worker, a secretary and an interpreter deliver services to various locales in the Navajo and Hopi Nations.[56]

B. Home-Based Programs Through State Compacts.

When tribes lack the funds or staff to mount a full scale tribal treatment program, the tribe may wish to contract with the State for culturally competent home-based care. For a variety of reasons, including spiraling impatient costs, negative consequences of foster care, recent legislation and research recommendations, many state systems are placing a new emphasis on home based care for children of all races.[57]

Statistics such as those showing a three to four times higher suicide attempt rate for children placed outside the home are prompting states to develop home-based programs.[58] In order to ensure that such services are culturally appropriate and to quell any liability fears on the part of the State arising from the delivery of services in Indian Country, Tribes will need to reach

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[56] McArthur, S., "A Child Psychiatry Team as a Resource for Identification and Treatment of Emotionally Disturbed Indian Children" in Encircling Our Forgotten (1988).

[57] Mannes, M. "Keeping Indian Families Intact: Native American Placement Prevention Initiatives" in Encircling Our Forgotten (1989).

[58] Graham, supra note 4 at 2.

agreements with the State regarding jurisdiction and treatment methods. Tribes may find it necessary to enter into "cross-therapuzation" compacts with state and municipal treatment centers.[59]

CONCLUSION

Regardless of the methodology employed, tribes must increase their involvement in juvenile mental health programs. Under the current system, many Indian youth are not receiving the treatment they need to develop into healthy adults. Other Indian adolescents find themselves labeled as "crazy" and unnecessarily hospitalized when they fail to live up to white middle-class norms. We are witnessing the initial stages of a neurotic chain reaction which, without swift intervention on both an individual and community level, will culminate in the destruction of tribal traditions. How sad it would be to center so much energy asserting our sovereign right to control taxation, real estate and water rights while ignoring our sovereign responsibility to protect our next generation.

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[59] Attorney General Opinion No. 90-32, issued March 5, 1991, authorized local and state law enforcement agencies to enter into cross-deputization agreements with Indian tribes. "Cross-therapuzation" agreements could arguably be based on 25 USC §452 and 25 USC §1919.